Medical Necessity

At UnitedHealthcare, we continually strive to improve the quality and cost of health care. We recognize that health care is evolving dramatically. Today, quality of care varies widely, gaps continue and costs are ever rising. Health reform is creating the need for greater cost transparency, effectiveness of care, and affordability. Continued advancements in health care technology, coupled with the growing number of choices for receiving health care, make it harder for members to navigate the system and make the most appropriate health care decisions.

To meet these challenges, UnitedHealthcare is implementing Medical Necessity across its legacy products as an additional approach among its medical management tools for improving quality and cost outcomes.

What is Medical Necessity?
Based upon a foundation of evidence-based medicine, Medical Necessity is a process for determining benefit coverage and/or provider payment for services, tests or procedures that are medically appropriate and cost-effective for the individual member. The Medical Necessity process:

- Provides an opportunity to address covered services at the individual level to support enhanced access to quality care for the member.
- Uses generally accepted standards of good medical practice in the medical community.
- Offers timely communication between health plans, members and providers to allow for prospective, concurrent and retrospective review as well as appeal rights for adverse determinations.

Components of Medical Necessity
To achieve a more consistent approach to quality care for our members, greater affordability for our customers and administrative simplification of our clinical approval systems, the Medical Necessity process has been initially designed with two components:

- Prior Authorization: Prior Authorization is the process of determining benefit coverage, based on medical necessity criteria, for services, tests or procedures that are appropriate and cost-effective for the individual member. It is a member-centric review to evaluate the clinical appropriateness of requested services in terms of the type, frequency, extent and duration.

- Inpatient Care Management: Inpatient Care Management is the use of medical necessity criteria in an inpatient hospital setting. During an inpatient concurrent or retrospective review, evidence-based medicine standards are used to evaluate whether the care provided to a member is at the appropriate level, whether there were any unnecessary delays in service, and if the length of stay is medically appropriate.
**Why Medical Necessity?**

Medical Necessity addresses the clinical appropriateness of health care expenditures – an interest that is shared among our customers, their covered persons, and UnitedHealthcare. Together, we seek:

- **Enhanced access to quality care:** Applying medical necessity criteria based on the best-available clinical science presents an opportunity to improve access to quality care by raising performance and reducing variation in medical practice. The end result engages consumers in informed decision-making.

- **Health care affordability:** Appropriateness of use will be evaluated based on the individual’s specific illness, injury, condition, disease or symptoms. The process promotes efficient delivery of high-quality care in a cost-effective manner.

**Comparison of Care Coordination and Prior Authorization Process**

<table>
<thead>
<tr>
<th>Key Processes</th>
<th>Care Coordination (currently in place)</th>
<th>Prior Authorization Process</th>
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</table>
| List of services that require Notification/Prior Authorization – Provider Requirements | Provider Notification requirements are communicated to UnitedHealthcare in-network providers. | Six additional Provider Prior Authorization requirements (in addition to the services currently on our Provider’s list):  
- Capsule Endoscopy  
- Cochlear Implants  
- Hyperbaric Oxygen Treatment  
- Joint Replacement  
- Outpatient Spine surgeries*  
- Sleep Apnea procedures and surgeries |
| List of services that require Notification/Prior Authorization – Member Requirements | Notification requirements are listed in member’s benefit plan document. | Six additional Member Prior Authorization requirements (in addition to the list of services currently in member benefit plan):  
- Diagnostic Catheterization  
- Electrophysiology implant  
- BRCA testing (breast cancer susceptibility)  
- Intensity modulated radiation therapy  
- MR-guided focused ultrasound  
- Sleep Apnea procedures and surgeries  
(Note: member is responsible for contacting UnitedHealthcare if member is in a PPO product or member accesses a non-network provider) |
| Source for Member Pre-Service Requirements | Member’s benefit plan document: either their Certificate of Coverage (COC) or Summary Plan Description (SPD). | No change |

*Inpatient Spine Surgeries currently on the Advanced Notification List

This chart is not intended to be all encompassing, but illustrative of some similarities/differences between the Care Coordination and Prior Authorization processes.
<table>
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<th>Key Processes</th>
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<tbody>
<tr>
<td>Responsibility for Notification/ Prior Authorization and liability if not obtained</td>
<td>Generally, members in plans with Prior Authorization can rely on their network physician to obtain Prior Authorization for services on the standard Prior Authorization Requirements list. Members will be responsible for obtaining Prior Authorization if they access a non-network provider, are in a product accessing a PPO network, or if the service is on a customer-specific (non-standard) Prior Authorization requirements list.</td>
<td>No change</td>
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<td>Clinical Review Performed</td>
<td>Coverage Review is performed according to member’s benefit plan. Includes evidence-based clinical reviews to identify plan exclusions including: cosmetic, unproven, investigational and experimental procedures.</td>
<td>Coverage Review is performed according to member’s benefit plan. Clinical review is expanded to include use of medical necessity criteria.</td>
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<tr>
<td>Notification of Coverage Determination</td>
<td>Determination letter is mailed to member with copy to physician.</td>
<td>No change</td>
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<tr>
<td>Liability if service is deemed not covered</td>
<td>Member is responsible for all charges resulting from the service.</td>
<td>Member is responsible for charges resulting from the service determinations if decision was rendered before the date the service is performed. Starting 4/1/12, member will be responsible for non-coverage determination if decision was rendered before the date the service is performed.</td>
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| Member Liability Scenarios                        | Member will be held liable in the following scenarios:  
- Service requires Notification and member had responsibility for providing Notification, but failed to do so.  
- Service was deemed not covered.  
- Inpatient bed day was deemed not covered due to custodial determination. | Member will be held liable in the following scenarios:  
- Service requires Prior Authorization and member had responsibility for obtaining Prior Authorization, but failed to do so.  
- Service is deemed not covered or not medically necessary per the member’s benefit plan, and the determination was communicated before service was rendered and member attestation is on file with the provider.  
- Inpatient bed day was deemed not covered due to custodial determination. |
**Key Processes** | **Care Coordination (currently in place)** | **Prior Authorization Process**
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Appeals Process | UnitedHealthcare will continue to adhere to all applicable federal and/or state appeal requirements for members. | No change

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For additional information and materials related to the Medical Necessity process, please contact your UnitedHealthcare representative.

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